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AFR/SA FOR ELOKEN, LDOBBINS, BHIRSCH, JHARMON
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SUBJECT: ZIMBABWE CHOLERA USAID DART HEALTH AND WASH ASSESSMENT REPORT

SUMMAY

¶1. The current cholera outbreak inZimbabwe began in August 2008. The outbreak resuled from a lack of access to clean water and non-unctional sanitation systems, largely due to the crrent regime's lack of maintenance, allowing forthe rapid spread of cholera through the country nd across borders, creating a regional crisis. Cholera has been a symptom of the breakdown in the ntional health and water and sanitation systems ad signals a growing public health crisis in the ountry. The lack of access to emergency obstetrical care increases concerns for maternal mortality, and in combination with the rise in communicable diseases, lack of vaccination, and lack of safe water leaves the country at risk to additional disease outbreaks. The current cholera crisis is compounded by a dire country-wide food security situation, raising serious malnutrition concerns. The U.N. World Food program has estimated that 5.5 million Zimbabweans will require food assistance in the first quarter of 2009. The cholera outbreak is occurring in a context of hyperinflation, a lack of progress towards a unity government, and what the U.N. Secretary General has termed a profound multi-sectoral crisis, encompassing food, agriculture, education, health, water, sanitation, and HIV/AIDS.

¶2. The response to the cholera outbreak has been hampered by challenges in coordinating the response between partners, and the lack of: 1) an overall strategy to guide partners; 2) timely and quality data; and 3) the use of the data to implement rapid health and water, sanitation, and hygiene (WASH) activities. The outbreak has been exacerbated by a lack of resources, particularly human resources to address case management, and the absence of a strong strategy for community-based activities for hygiene, health education, and case identification and treatment.

¶3. The objectives of the humanitarian response are to decrease

transmission and to limit mortality. The health and WASH clusters in Zimbabwe are beginning to coordinate efforts to ensure timely response to outbreaks and assess areas at risk to reduce transmission. The U.N World Health Organization (WHO) is planning to set up a cholera command and control center, which will technically advise implementing partners in the areas of disease surveillance, case management, infection control and WASH, social mobilization, logistics, and communications. The response to cholera should be viewed in the context of a declining health system. Unless the lack of general primary health care is addressed, outbreaks of similar significance will continue to affect the country and the region. In the absence of a response by the current regime to the crisis, donors should initiate short-term efforts to save lives and reduce the spread of cholera and promote basic primary health care. End Summary.

SITUATION ANALYSIS

¶4. An outbreak of cholera that began on August 20 in the Chitungwiza suburb of Harare has now spread to affect 9 out of 10 provinces in Zimbabwe and resulted in 20,896 suspected cases and 1,123 deaths as of December 18, according to WHO. The case fatality rate (CFR), which should be under 1 percent, has been unacceptably high with an average of 5.4 percent reported to date. In some areas, the CFR has reached as high as 30 percent, according to WHO. Deaths in the community, as opposed to deaths at a medical facility, account for between 20 to 50 percent of total deaths, suggesting late arrival to cholera treatment centers (CTCs) or lack of access to immediate and appropriate health care.

¶5. More than 50 percent of the cases have been reported from urban and peri-urban Harare, and along the borders of Mozambique and South

Africa in Mudzi and Beitbridge districts respectively. The age distribution shows a typical trend, with the most affected between 20 to 30 years old with an equal sex distribution. The trends in the highly-affected regions are following a natural decline, but peaks in cases are still reported throughout the country. The largest recent outbreak has been reported in Chegutu district, where there was a rapid rise in cases with approximately 275 admissions from December 8 to 12 to the CTC, with 85 deaths and a CFR of 30.9 percent.

¶6. The source of the outbreak was probably the contamination of the main water supply in high density urban areas. The current cholera crisis is characterized by widespread occurrence of cases with periodic explosive outbreaks in high density urban and peri-urban areas. The outbreak spread through population movement and traditional funeral practices, including washing the body of the deceased. The outbreaks observed in Chitungwiza and Chegutu districts suggest a point source infection with a sudden spike in caseload for 2 to 5 days, when most of the cases and deaths occur. The high mortality rates reported during the early phase of the outbreaks argues for strengthening the early warning and response system. Some rural areas have not reported cholera cases, which may be due to functioning WASH systems, a lack of detection or reporting of cholera cases, or the absence of cholera in these rural areas to date.

¶7. WHO has suggested that up to 60,000 people may fall ill from cholera over the next year. Cholera cases are expected to increase due to the onset of the November to April rainy season and population movement for the holiday season. This is compounded by increasing food insecurity and malnutrition, continued decline of the public health system, and deteriorating WASH infrastructure. Vulnerable groups include mobile vulnerable populations, apostolic sect members, who refuse treatment, and HIV/AIDS patients.

USG RESPONSE TO DATE

¶8. Beginning December 5, the USAID Disaster Assistance Response

Team (USAID/DART) health advisor and U.S. Centers for Disease Control and Prevention (CDC) WASH advisor have conducted meetings with Government of Zimbabwe (GOZ) Ministry of Health and Child Welfare (MOHCW) officials, USAID/Zimbabwe and CDC staff, U.N. agencies, and non-governmental organizations (NGOs). The health and WASH advisors have participated in field assessments in the Harare suburbs of Budiriro and Chitungwiza, as well as Chegutu, Mudzi, Mazowe, and Mutoko districts.

¶9. The USAID/DART advisors examined the effectiveness of the response to date in reducing spread of the outbreak, including disease surveillance and early warning, access to safe water and sanitation facilities, social mobilization for hygiene promotion and health education, and limiting mortality through early detection, proper treatment, and referral. The advisors also examined overall coordination efforts to date.

CLUSTER COODINATION

¶10. Overall coordination within the health cluster has been lacking due to the absence of a trained health cluster coordinator. This has lead to difficulties in setting priorities and a strategic direction for the response from the health and WASH clusters, including an assessment of what has been done already, a needs assessment, and a gap analysis ("who does what where"), in order to inform response capacity. The USAID/DART and other donors have reinforced the urgency of deploying a strong health cluster coordinator and encouraged improved collaboration between the health

and WASH clusters. In support of the MOHCW, WHO is planning to set up a cholera command and control center to guide, coordinate, monitor, and evaluate the cholera response. Donors have advocated for a clear exit strategy for supporting the command and control center.

¶11. The WASH cluster has been better organized and more active, although a number of limitations remain. The response of the cluster has been somewhat slowed by the lack of clear data from the health cluster on how the outbreak is spreading and where potential new outbreaks may arise. The delays are due in part to the lack of timely reporting of cases to the health cluster, as well as poor communication between the clusters. Recent meetings between the two clusters should alleviate some of the issues. On December 21, the WASH cluster drafted a "who does what where" document, which the USAID/DART is evaluating.

¶12. The USAID/DART has met with representatives from the U.K.'s Department for International Development (DFID) and the European Community Humanitarian Aid Office (ECHO) to ensure good coordination from the donors so that gaps are filled and efforts are not duplicated. There was general agreement that the leadership for the response is critical, including increased leadership from the U.N. Office for the Coordination of Humanitarian Affairs (OCHA). The donors have requested a joint action plan with a gap analysis, including resource needs for all partners.

SURVEILLENCE AND EARLY WARNING

¶13. The lack of rapid data collection, analysis, and dissemination to the health and WASH clusters has seriously delayed a timely response to the cholera outbreak. The slow collection of data is due to a number of factors such as lack of logistical support, communications, and human resources. In addition, there are multiple flows of data from the district to central level and from the MOHCW and NGOs. To address this WHO will implement direct cholera reporting to the central level.

¶14. Little analysis has been made of data trends to prioritize areas for immediate response. Currently, only raw numbers are being provided, inconsistently, to partners through OCHA. There has been no operational platform to ensure that the cluster leads and

partners are notified immediately to deploy resources to respond to the affected areas. Similarly there is little investigation into high risk areas to look at water quality and provide health promotion and health education activities. The cholera command and control center will help ensure there is a timely response by the health and WASH clusters. The WHO epidemiologist has compiled a countrywide epidemiologic bulletin, which was released on December ¶15.

¶15. Laboratory confirmation of cholera cases is being conducted both at the National Reference Laboratory and at peripheral labs in district hospitals. According to a microbiologist at the reference lab, samples are collected and tested from each new site in which cases are detected. Antibiotic tests have shown sensitivity to ciprofloxacin, tetracycline, and erythromycin. The reference laboratory has minimal amounts of basic supplies. CDC is compiling a list of basic media and supplies needed by the lab in order to ensure continued monitoring of the outbreak for changes in antibiotic sensitivity. As part of the cholera command and control center, WHO has proposed conducting an assessment of the central and regional laboratories.

¶16. The breakdown of the national surveillance and early warning system has resulted in only 30 percent of the information reported in a timely and complete way. This also puts the country at risk for other communicable diseases.

WASH SITUATION

¶17. In urban areas of Zimbabwe the lack of a reliable power supply and shortages of chemicals for water treatment have resulted in shutdowns of the municipal water supplies in Harare and other areas, forcing people to use alternative, unsafe, water supplies. In addition, the lack of municipal water affects urban sewer systems with increased numbers of blockages in the lines due in part to reduced flows. The intermittent flow of water has resulted in ruptured pipes, which combined with overflowing sewers has likely led to cross-contamination of drinking water supplies.

¶18. In some parts of the high-density suburbs surrounding Harare there are numerous shallow hand-dug wells. Some of the wells are lined and protected above ground, while others are completely unprotected. The wells provide water for washing and bathing during times when the tap water is not flowing. However, with prolonged water shortages in recent months, residents often depend on the wells for driking water. Many of the wells are prone to surfac runoff or subsurface contamination, particularl with increased rains in recent weeks. It is notclear how important a role the wells have playedin the current cholera outbreak but the risk of ontamination is evident.

¶19. In rural areas, smilar issues have occurred in smaller water treament plants such as Mudzi Growth Point, where the water treatment plant stopped supplying water due o a lack of aluminum sulphate and chlorine as wel as power shortages. In communities that rely on boreholes with hand pumps, the inability of the community or local authorities to repair broken hand pumps has forced families to use unsafe sources such as shallow unprotected wells, scoop holes, and surface water. In Mudzi, Oxfam/Great Britain estimated that half of the hand pumps have broken down, leaving a large proportion of the population without access to a safe water supply.

WASH RESPONSE

¶20. In Harare, the U.N. Children's Fund (UNICEF) is currently supplying aluminum sulphate and chlorine for the main water treatment plant in order to ensure continued water supply. The International Committee of the Red Cross is supplying replacement parts and tools for the water treatment plant and distribution

system as well as providing tools to unblock the sewer lines. This should lead to a more reliable supply of water than in the past, at least in the short term. However, due to the water rationing and the many breaks in both the water and sewer lines, there is still the risk of contamination of the distribution network and further spread of cholera.

¶21. The other main WASH response in both urban and rural areas is water tankering, either from municipal water treatment plants or from mechanized boreholes, to an elevated bladder or tank. This has allowed WASH implementing partners to provide bulk quantities of potable water to cholera-affected communities in a short time span. USAID's Office of U.S. Foreign Disaster Assistance (USAID/OFDA) does not normally support water tankering as a solution, but given the emergency situation, water tankering should continue for the immediate future.

¶22. Due to the explosive nature of the outbreaks in some urban areas, the combination of water tankering, distribution of aqua tabs, water containers, and soap, and hygiene promotion are all necessary.

CASE MANAGEMENT

¶23. Case management at the CTCs has been variable, from putting all patients on intravenous fluids, to sending every individual home with oral rehydration salts (ORS) and an assortment of antibiotics, to providing no antibiotics. In some areas doxycycline has been distributed for prophylaxis to communities where cholera cases have been found. The MOHCW and WHO have standard cholera treatment protocols, which were not observed to be posted for use by the health staff. WHO intends to deploy staff from the International Centre for Diarrheal Disease Research, Bangladesh, to help improve case management.

¶24. The local health staff from the doctors to the community health workers are quite motivated, however, there is no incentive due to lack of salaries and high cost of transport and food. DFID and ECHO are initiating a retention scheme for health care providers to supplement the lack of salaries as an emergency stopgap, although without a clear exit strategy. On the positive side, there are many international NGOs with strong partners and community volunteers already working in country that could be supported for the response.

¶25. Currently, there is not a clear picture of the level of medical supplies in the country. Numerous NGO, U.N., and GOZ partners are bringing in medical supplies to manage cholera, including a UNICEF airlift reported on December 22. USAID/OFDA and other donors have asked UNICEF and WHO to conduct a gap analysis and needs assessment.

SOCIAL MOBILZATION

¶26. The USAID/DART has prioritized the formation of a strong and coordinated response at the community level. This includes hygiene promotion and health education, including care seeking behavior, home-based care and feeding practices, and active case finding and early treatment at the community level with ORS. Many NGO partners are interested in this component but there is little strategic direction or standardized tools currently available. There are also a variety of methods to get messages and ORS out to communities, including development health programs, food aid, and HIV programs. Such resources could be better coordinated for a more rapid and robust community-level prevention and response program. The activities would not only benefit the response to the current outbreak, but also would build capacity for community-based mechanisms to respond to other emergencies.

RECOMENDATIONS

¶27. The health and WASH clusters need to improve coordination and leadership, consider a joint needs assessment, and prioritize early warning to alert both health and WASH implementing partners of new outbreaks or potential hotspots on a timely basis. The clusters should also develop a clear strategy for prevention efforts in areas at high risk for cholera, responding to newly emerging areas with increasing cases of cholera, and monitoring areas with high cholera caseloads.

¶28. Newly emerging areas with increasing cases should be targeted with hygiene promotion, the provision of safe water via tankering or household level disinfection, distribution of water storage vessels and soap, and health education and distribution of ORS. Measures should also include active case finding and referral for care, setting up a CTC, and a resources needs assessment.

¶29. In high-risk communities such as urban and peri-urban areas, hygiene promotion activities and an assessment of the quality and reliability of drinking water sources should begin as soon as possible and should not wait for an outbreak to occur. In addition, health activities could include active case finding and a needs assessment for additional resources for a local outbreak.

¶30. The health and WASH clusters should continue to monitor heavily burdened areas such as Budiriro, Beitbridge, and Mudzi, and continue to provide care at the CTCs as needed. WASH interventions should continue at a minimum until no new cases are detected in the community, and if resources are available until the outbreak subsides.

¶31. The health and WASH clusters should initiate a task force on social mobilization to ensure an overall strategy on community mobilization, better cluster coordination on health education and hygiene promotion messages, analysis of existing community health worker and hygiene promoter networks and to ensure that the use of standardized information education and communication materials.

¶32. Providing interim support to the primary health care system would help to prevent further outbreaks of communicable diseases, maternal deaths, and to better monitor nutritional status of the population. Any long term support to reviving the GOZ's collapsed health care system should be contingent on government reform. (Note: While the USAID/DART recognizes the need for a robust response to save lives and alleviate suffering, close monitoring of donor resources for the cholera crisis is important, given the possibility that the current regime will attempt to use the donor response to the cholera crisis for personal or political profit. End Note.)

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